- 13 Lopez L, Colan SD, Rhodes LA, et al. Differential survival after surgical or balloon valvotomy for critical aortic stenosis in infants [abstract]. J Am Coll Cardiol 1992;25A:705.
- 14 Fischer DR, Ettedgui JA, Park SC, Siewers RD, Del Nido PJ. Carotid artery approach for balloon dilation of aortic valve stenosis in the neonate: a preliminary report. J Am Coll Cardiol 1990;15:1633-6.
- 15 Rhodes LA, Colan SD, Perry SB, Jonas RA, Sanders SP.
- Predictors of survival in neonates with critical aortic stenosis. Circulation 1991;84:2325-35.

 adusans EJ, Parsons JM, Qureshi SA, Baker EJ, Tynan MJ. Results of percutaneous balloon dilatation for critical control of the control cal aortic stenosis in neonates with severe endocardial
- fibroelastosis [abstract]. Br Heart J 1989;61:470.

 Redington AN, Booth P, Shore D, Rigby ML. Primary balloon dilatation of coarctation of the aorta in neonates. Br Heart J 1990;64:277–81.

SHORT CASES IN CARDIOLOGY

Recurrence of Churg Strauss vasculitis in a transplanted heart

R A Henderson, P Hasleton, B N A Hamid

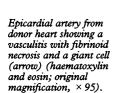
In October 1987 a 22 year old man with Churg Strauss syndrome and cardiac failure underwent orthotopic cardiac transplantation.1 Postoperatively he had recurrent attacks of asthma associated with eosinophilia, but there were no other features of Churg Strauss syndrome. Routine endomyocardial biopsy specimens showed no rejection or vasculitis until March 1991 when an episode of moderate myocardial rejection was treated with immunosuppressive therapy. In January 1992 cardiac catheterisation showed moderate impairment of left ventricular function and diffuse left coronary artery disease but the right coronary artery was angiographically normal. In March 1992 he suddenly collapsed with electromechanical dissociation and despite prolonged resuscitative efforts he died one hour later.

At necropsy there was severe pulmonary oedema and the heart was enlarged (486 g). Histological examination of the donor myocardium showed foci of myocardial fibrosis with patchy areas of rejection and myocyte

damage. There was vasculitis in the intramyocardial and epicardial arteries. In the right coronary artery there was fibrinoid necrosis in the adventitia and necrosis of the vessel wall, with chronic inflammation containing lymphocytes, plasma cells, and a few eosinophils (figure). The proximal right coronary artery was occluded with thrombus. A postmortem diagnosis of Churg Strauss vasculitis was made.

Cardiac transplantation in patients with a systemic disease is controversial, because non-cardiac manifestations of the disease may influence prognosis and the disease may affect the donor heart. This case suggests that Churg Strauss syndrome is a relative contraindication to cardiac transplantation because vasculitis may recur in the transplanted heart.

Thomson D, Chamsi-Pasha H, Hasleton P. Heart transplantation for Churg-Strauss syndrome. Br Heart J 1989;62:409-10.



Departments of Cardiology and

Cardiothoracic

R A Henderson

Department of

Pathology, Trafford General Hospital,

Department of Cardiology,

Wythenshawe Hospital,

Manchester M23 9LT.

Accepted for publication 17 September 1993.

P Hasleton

Manchester

B N A Hamid

Correspondence to: Dr R A Henderson,

Pathology, Regional

Centre, Wythenshawe Hospital, Manchester

